Strategic Planning Process for 2010-2013

A Report to the North Carolina General Assembly

Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

July 1, 2010

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Executive Summary

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is pleased to report to the North Carolina General Assembly on the Division's strategic planning process for 2010-2013 as required by Session Law 2006-142, House Bill 2077. That legislation requires the Division to publish a three-year strategic plan for 2010-2013 by July 1, 2010.

At this time, the Division is participating in the strategic planning initiative of the Department of Health and Human Services (DHHS) led by Secretary Lanier Cansler. This initiative is part of a planning process called for by Governor Purdue and overseen by the Office of State Budget and Management due in the fall of 2010. The DHHS initiative involves all divisions and offices of the Department in the development of a uniform mission, vision and values applicable to all human services, as well as goals, measurable objectives and budgets related to all services of the Department. The Division believes its original mission, vision and guiding principles are fully included in the Department's broader view and is committed to this process.

The Division recognizes that a strategic plan requires specification of goals, measurable objectives and action steps as shown in the Division's Strategic Plan for 2007-2010 published July 1, 2007. As a participant in a larger planning process that is currently underway, this report is a preliminary statement of the Division's intentions and strategies as it enters the planning process with DHHS.

The Division continues commitment to the five objectives defined in Strategic Plan 2007-2010 and has identified specific strategies for further development of the public system of mental health, developmental disabilities and substance abuse services system. The objectives specified in 2007 are:

- ***Establish and support a stable and high quality provider system with adequate number and choice of providers of desired services.***
- ***Continue development of comprehensive crisis services.***
- ***Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system.***
- ***Improve consumer outcomes related to housing.***
- ***Improve consumer outcomes related to education and employment.***

Chapter 1 provides a brief historical perspective describing the planning process undertaken during reform of the system, along with an exploration of the current environmental factors affecting where we are now. North Carolina's response to health

care reform and the economic situation will have significant influence on how we proceed.

Chapter 2 identifies multiple accomplishments as called for and guided by the 2007-2010 strategic plan and reports on the original measures of success. During just three years, residents in North Carolina communities have gained increased access to:

- Mobile crisis teams that can respond immediately and on site in an emergency.
- Inpatient psychiatric beds at local community hospitals.
- Integration between behavioral health and physical health services.
- Law enforcement officers trained in crisis intervention.
- Walk-in clinics with access to a psychiatrist on site or through telepsychiatry conferencing equipment.
- A team trained to work with individuals in crisis who have developmental disabilities and mental health issues.
- Crisis respite beds enabling families to restore calm and stabilization.
- Person centered planning in the choice of services and supports.
- Highly qualified providers.

State operated facilities are better able to provide evidenced based care and safety for individuals who have the most intense needs and who are unable to provide for themselves or obtain needed care in the community.

Other notable changes have occurred throughout the system since 2007. There is greater focus on integration of services and supports within communities. There is heightened attention to performance and outcomes. There is commitment to work smarter with limited funding through tough economic times. There is an increased spirit of collaboration across the State and between State and local levels. There is greater willingness among all stakeholders to be accountable.

The State has entered a new era of best practices, information technology, health care reform, communication, quality management and financial management. New strategies are necessary and available to achieve the goals and objectives.

The mission, vision, goals and values identified for all divisions and offices of DHHS are presented in chapter 3. Chapter 4 describes the Division's strategies for continued focus on the objectives set in 2007. The strategies include:

- Continued development and administration of the Community Alternatives Program-Mental Retardation/Developmental Disabilities Waiver (CAP-MR/DD).
- Implementation of the Critical Access Behavioral Health Agency model (CABHA) for mental health and substance abuse services.
- Expansion of local management entities' participation in the State's 1915 (b)/(c) Medicaid waiver.
- Continued integration of mental health and substance abuse services with primary heath care.

- Continued collaboration with State and local partners regarding housing, employment and education.
- Ensuring successful performance of local crisis services.
- Improved guidelines for involuntary outpatient and inpatient commitment processes.
- Effective management of the overall system.

Ultimately, success rests with all stakeholders, including consumers and their families, providers, local management entities (LMEs), as well as the Division, the Department and legislators. With tight resources for the foreseeable future, innovation hinges more than ever on skilled leadership. Yet, with everyone's participation and commitment, the accomplishment of the strategies will produce concrete, visible progress and changes for consumers and families over the next three years.

Chapter 1. Where are we now?

The purpose of a strategic plan is to clarify where we are now, where we want to be in three to five years, how we plan to get there, and how we will evaluate our progress. Clarification of where we are now takes into consideration the historical perspective, the most recent accomplishments, and recognition of environmental factors that affect operations and the capacity to effectively pursue the vision and mission. These lay the foundation in preparation for future steps.

Historical Perspective

Nine years ago North Carolina charted a course to reform public services for people who experience mental illness, developmental disabilities and substance abuse. The North Carolina General Assembly mandated reform of how services were managed and delivered in the state. The changes affected virtually every individual involved in the system – consumers and family members, management and staff of state operated facilities and community service providers, and State and local government.

In response to the mandate, the North Carolina Department of Health and Human Services (DHHS or the Department) and its Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) published State Plan 2001: A Blueprint for Change and an annual plan on July 1 of each State fiscal year through 2005.[1]

In 2006, the General Assembly mandated in Session Law 2006-142, HB 2077, that the Division publish a three-year strategic plan beginning with state fiscal year (SFY) 2007-2008. The first plan was published July 1, 2007. The accomplishments required by that plan are presented in chapter 2.

Environmental Factors

The years of 2007 through 2010 have been rewarding, challenging and revealing for the country and the State of North Carolina with changes in economic stability, health care reform, housing, job security, the role of government, political values, additional support for veterans, and scientific and medical developments.

When Governor Beverly Purdue took office in 2009, she focused North Carolina state government on efficiency, accountability and results, and identified priorities on which her administration would focus. All state agencies are participating in a strategic planning process that includes results-based budgeting, performance and accountability and is overseen by the Office of State Budget and Management.

[1] To see previous strategic plans and the accomplishments made across the system during 2001-2006: http://www.ncdhhs.gov/mhddsas/stateplans/plans_accomplishments/index.htm

In alignment with this endeavor, Lanier Cansler, Secretary of DHHS, is leading a department wide strategic planning effort to develop and implement uniform mission, vision and values applicable to all of its divisions and offices, as well as goals and performance measures applicable to all services. The Division is a full participant in this process.

The Department will submit its strategic plan due to the Office of State Budget and Management in October 2010 including key performance measures and targets to enable continuous monitoring and evaluation of progress toward the goals and objectives. These measures will include budgetary information to enable review of costs and wise use of the resources available, especially in this time of economic hardship. In light of the economic down turn that began in 2008, all State agencies are focusing on their core missions and faced with hard choices in the use of limited resources.

The Impact of the Patient Protection and Affordable Care Act (HR 3590) on the MH/DD/SA service system[2]

The nation's healthcare reform is another environmental factor that must be understood and taken into consideration as the Division proceeds in the design and development of the public mental health, developmental disabilities and substance abuse services system.

The final health insurance reform legislation is designed to ensure all Americans have access to quality, affordable health care and significantly reduce long-term health care costs. Key provisions of this legislation will have significant impact on those who receive services from the mental health, developmental disabled and substance abuse service system. Overall the legislation addresses key areas intended to:

- Offer quality and affordable health care for all Americans.
- Provide investments in Medicaid and the Children's Health Insurance Program.
- Improve the provision of Medicare services.
- Improve prevention of chronic disease and public health.
- Increase the competency and availability of the healthcare workforce through investments in training doctors, nurses and other health care providers.
- Focus on transparency and program integrity by providing consumers with information about their physicians, hospitals and medical equipment companies.
- Improves access to innovative medical therapies.
- Make long-term support and services more affordable.

The provisions related to excluding individuals with pre-existing conditions from receiving insurance will apply to people with serious mental illness, developmental

[2] References: NAMI, 2010 , *Provisions in the Senate Passed Health Reform Legislation for Americans Living with Serious Mental Illness and Their Families*; and House Committee on Ways and Means, Energy and Commerce, and Education and Labor, March 23, 2010: *Affordable Health Care for America*, Summary.

disabilities and a substance abuse diagnosis. There are also provisions in the legislation that provide for mental health and substance abuse parity and a voluntary public, long term care insurance program to help individuals with serious mental illness and those with functional limitations. Those who qualify would receive assistance to purchase services that will assist in their maintaining personal and financial independence. On the Medicaid front, the legislation calls for an increase in the number of people who will qualify for services when the poverty level calculation changes to 133% of the federal poverty level in 2014. Among other provisions, Medicaid will begin coverage of habilitative services and allow states to provide full home and community based services (HCBS) to Medicaid beneficiaries through a state plan amendment instead of a waiver.

In the future it is anticipated consumers with mental illness will be guaranteed access to all medications for mental illness as the legislation calls for codifying the legal authority to ensure all medications to treat mental illness are on the prescription drug plan formularies.

SAMHSA's Strategic Initiatives

Another environmental factor that may affect the public MH/DD/SA services system is the future use of funds from the Mental Health Block Grant (MHBG) and Substance Abuse Prevention/Treatment Block Grant (SAPTBG). In June 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services held a conference with representatives from all states to discuss 10 strategic initiatives in response to health care reform. The initiatives are more prescriptive in the use of MHBG funds than in the past.

In summary, these environmental factors may bring considerable changes in the way mental health, developmental disabilities and substance abuse services are delivered, though the details of those changes are not yet known.

Chapter 2. What We Accomplished in 2007-2010

In the midst of changes at the national and state levels, the Division achieved many of the objectives it set in 2007, while adapting to a reduction of staff and state funding at all levels of the system. Taken together, all the accomplishments can be considered a foundation for securing and stabilizing the structure the Division and all stakeholders have worked to build.

Appreciation of our Partners

We acknowledge and appreciate the collaboration and contributions of many partners in accomplishing the objectives of the 2007-2010 strategic plan. In addition to the leadership of the Governor and of the Department of Health and Human Services and collaboration with many divisions and offices within the Department, we recognize the contributions of:

- Individual consumers and their family members.
- The North Carolina General Assembly (NCGA), including the Legislative Oversight Committee (LOC).
- The State Consumer and Family Advisory Committee (SCFAC).
- Local Consumer and Family Advisory Committees (CFACs).
- Local Management Entities (LMEs).
- The NC Council of Community Programs.
- Providers of mental health, developmental disabilities and substance abuse services.
- The NC Hospital Association.
- The Division's External Advisory Team.
- The NC Association of County Commissioners.
- Advocacy organizations.
- The NC Institute of Medicine (NC IOM).
- The NC Housing Finance Agency (NCHFA).
- The NC Interagency Council for Coordinating Homeless Programs (ICCHP).

We also recognize the newly formed Division of State Operated Healthcare Facilities (DSOHF) that was once a section of the Division. DSOHF was established to oversee the 15 State facilities including the state psychiatric hospitals, the developmental centers, the neuro-medical treatment centers, the alcohol and drug abuse treatment centers and schools. The staff of DSOHF has continued the commitments made in the 2007-2010 strategic plan and their accomplishments are included here. DSOHF is also a participant in the DHHS strategic planning process. For additional information, see the DSOHF web site: http://www.ncdhhs.gov/dsohf/.

Strategic Objectives of 2007 through 2010

Specific accomplishments, challenges, and outcome measures are recognized for each of the objectives in this chapter, providing an update and picture of the MH/DD/SA services system at the end of the 2007-2010 planning time period. The strategic objectives of the strategic plan for 2007-2010 include:

- **Establish and support a stable and high quality provider system with adequate number and choice of providers of desired services.**
- **Continue development of comprehensive crisis services.**
- **Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system.**
- **Improve consumer outcomes related to housing.**
- **Improve consumer outcomes related to education and employment.**

The successful effects of some of the objectives may be more readily apparent than others. For example, considerable change is apparent throughout the State with regard to the availability of local crisis services since 2007. That development is ongoing as services and protocols are refined in their operations and in interaction with each other and with established community services and supports.

Yet, as we originally indicated, ongoing effort and time beyond 2007-2010 is necessary to fully develop employment opportunities in communities for consumers who desire to and can work. Housing options continue to develop as well. Both require extensive collaboration with other state and local partners that have primary responsibility for education, employment or housing and both are affected by the current economic climate.

Sometimes one solution was found to meet requirements of two or more objectives. For example, the work of three different objectives focused on consumers who are viewed as high risk or high cost. A high quality provider system is required to ensure available, appropriate, intensive and ongoing care. High risk individuals are defined in statute as needing crisis services three or more times in the last year, so the ability of crisis services to respond is imperative. A consistent approach to care coordination was addressed in the standardization objective.

For each objective, the Division uses this opportunity to share many accomplishments made and challenges faced across the system during the last three years. The Division remains committed to continuing this work as it evolves. Additional information about the accomplishments can be found on the Division's web site: http://www.ncdhhs.gov/mhddsas/

Establish and support a stable and high quality provider system with an adequate number and choice of providers of desired services

The last three years involved an intense focus on the provider system of mental health, developmental disabilities and substance abuse services and supports across the State. The action steps for this objective as defined in 2007 focused Division efforts on:

- Empowering consumers to actively exercise choice, to participate in person centered planning and to expect best practices and service quality.
- Establishing system benefits and standards to reflect best and preferred practices for each age/disability group.
- Defining statewide provider performance standards and clarifying LMEs' responsibility for holding providers accountable and reporting performance to the public.
- Establishing strategies for providers to enhance quality and effectiveness.
- Continuing to implement best practices in stated operated facilities to complement community services.

Measures of Objective

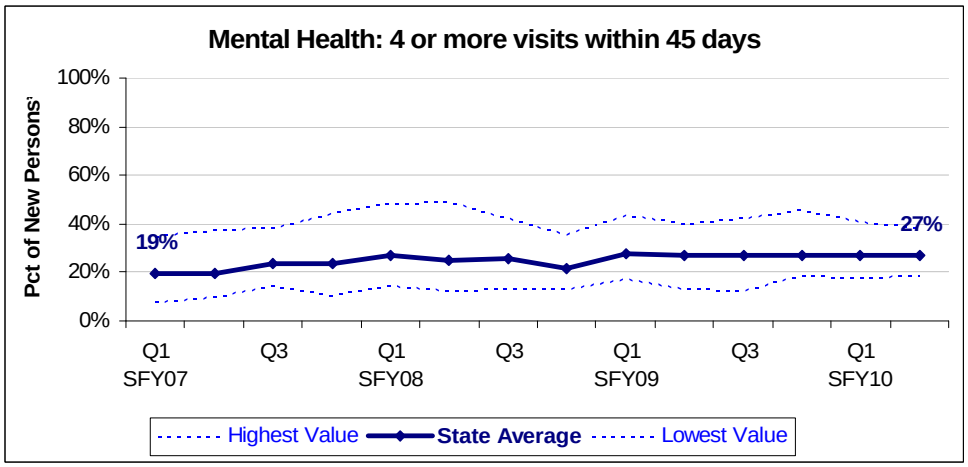
Several outcome and performance measures were initially chosen to measure success of this objective. Although targets were not set in 2007, each measure shows progress.

Increased percentage of consumers receiving timely and adequate care.
Data Source: Community Systems Progress Report, Timely Initiation & Engagement[3]
For persons with mental illness, developmental disabilities, and addictive diseases to recover control over their lives and maintain stability, they need continuing access to supports and services. Initiation and engagement are nationally accepted measures of continued access.

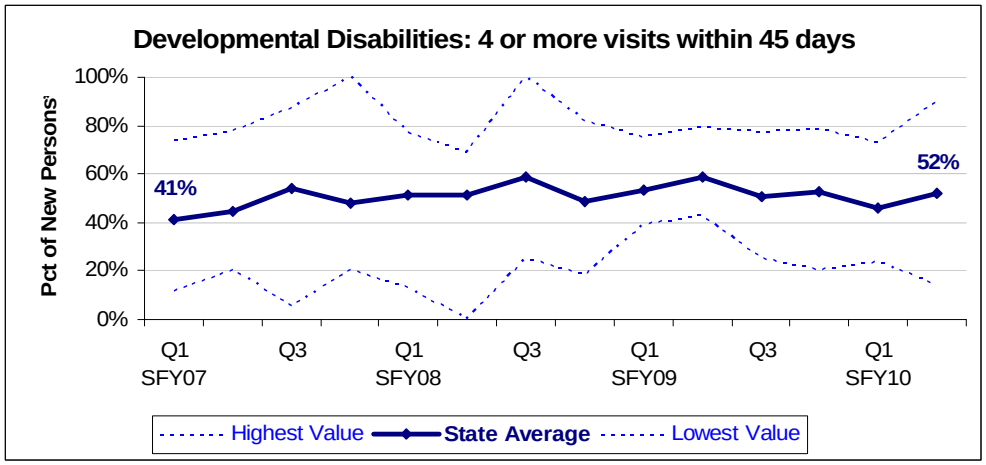
The following tables show the percentage of new persons served statewide that were engaged in treatment as evidenced by having at least two visits in the first 14 days of care followed by at least two more visits in the next 30 days (four or more visits within 45 days). Between the beginning of SFY 2007 and the second quarter of SFY 2010 the percent of new consumers rose for each disability group.

[3] For more details, see the Community Systems Progress Reports, SFY 06-07 through SFY 09-10 http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

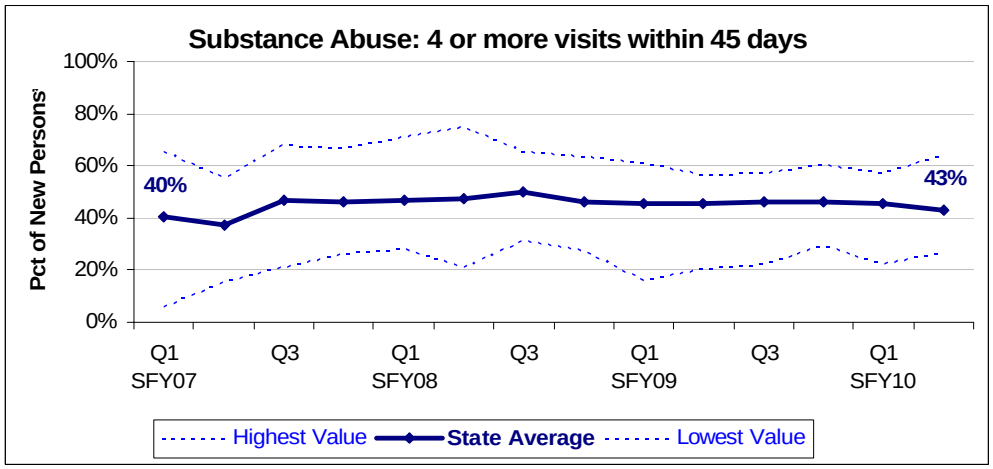
- New consumers of Mental Health services rose from 19% to 27%.



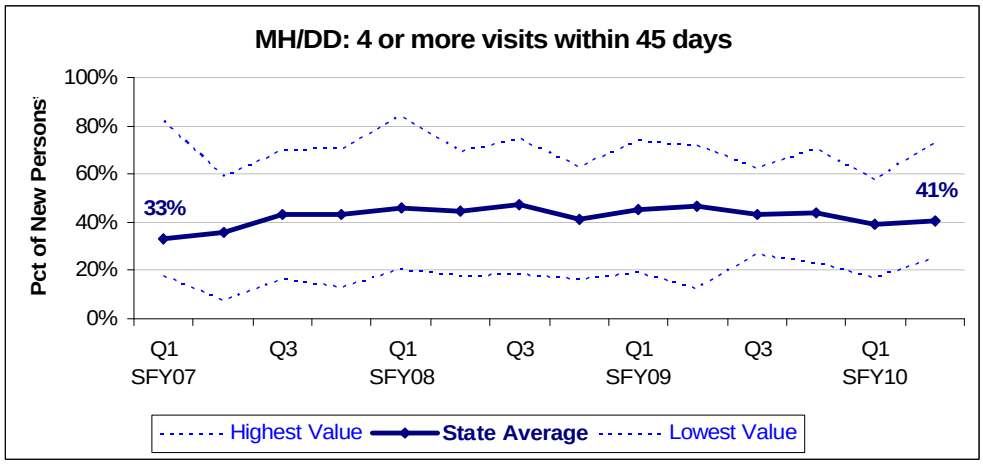
- New consumers of Developmental Disabilities services rose from 41% to 52%.



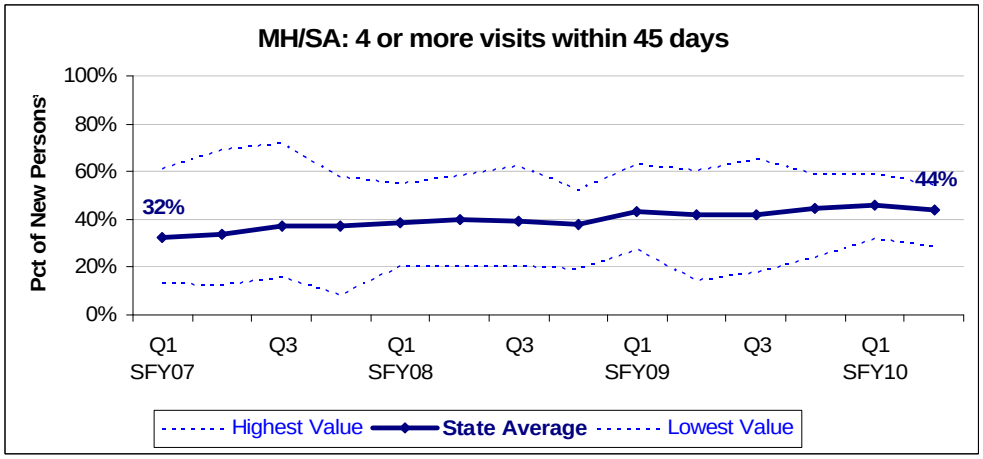
- New consumers of Substance Abuse services rose from 40% to 43%.



- New consumers with dual diagnoses of mental health and developmental disabilities (MH/DD) rose from 33% to 41%.



- New consumers with dual diagnoses of mental health and substance abuse (MH/SA) rose from 32% to 44%.[4]



Increased proportion of public resources spent on evidence based practices (EBP) and best practices

Data Source: Medicaid and IPRS claims paid through month and year shown.

Table 1 shows that the number of individuals receiving selected evidence based practices and best practices and that the Medicaid and State funds spent on these services have increased since 2007. Both the availability and use of these services have grown.

[4] Highest value and lowest value in the graphs refer to high and low performing LMEs.

Table 1. Use of Evidence Based and Best Practices

		SFY07	SFY08	SFY09	SFY10 YTD* (June '09 – March '10)
Dollars Expended	All Services	$2,487,182,919	$2,579,994,447	$2,502,785,852	$1,653,277,442*
	EBP / BP	$ 60,373,229	$ 104,836,849	$ 232,960,610	$ 274,635,964*
	% EBP/BP	**2%**	**4%**	**9%**	**17%**
Persons Served	All Services	283,704	294,893	307,447	264,047*
	EBP / BP	11,537	16,021	24,426	31,611*
	% EBP/BP	**4%**	**5%**	**8%**	**12%**

*Data for SFY10 include 9 months' expenditures, based on claims paid through March 31, 2010. Percentages can be taken as an estimate for the entire fiscal year, even though the raw numbers undercount final expenditures and persons served for SFY10. Data for other years each represent 12 months' expenditures, based on claims paid through September 30, 2007 for SFY07, November 30, 2009 for SYF08 and March 31, 2010 for SFY09.

Evidence based practices are those that have been shown to be effective in multiple, scientifically conducted research studies, while best practices are accepted clinical practices that demonstrate success for the individuals served. The evidence based practices reported here include Assertive Community Treatment Team (ACTT) and Multisystemic Therapy (MST). Best practices include Community Support Team (CST), Intensive In Home (IIH), Psychosocial Rehabilitation (PSR), Substance Abuse Intensive Outpatient Program (SAIOP), and Substance Abuse Comprehensive Outpatient Treatment (SACOT). Other evidence based and best practices are available from providers but are not identifiable by claims data.[5]

The number of providers of each of these services has changed over the three years. For example, from the end of SFY07 to the end of SFY09 the number of ACTT providers has increased from 49 to 54; the number of MST providers has grown from 12 to 17; and the number of IIH providers has grown from 57 to 296.

Increased percentage of providers that are nationally accredited for each disability group

Data Sources: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), the Council on Quality and Leadership (CQL), and The Joint Commission (TJC).

[5] For definitions of services, see: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm

Beginning in March 2006, providers of enhanced services were required to become endorsed by the LME and to become accredited by one of the approved national accrediting bodies (named above) within three years of the providers' date of enrollment as a community services provider. The Division's survey of all providers in December 2007 revealed only three percent (3%) of all providers achieved the accreditation standard. As of May 2010, 66 percent of the 970 providers of community services are fully accredited and another 13 percent are in the process of becoming accredited.[6]

Table 2. Status of provider accreditation by type of provider as of March 2010

	Fully Accredited	Accreditation in Process	Accreditation not begun	Total #
Providers of community services	638 (66%)	128 (13%)	204 (21%)	970
Providers of residential services	377 (53%)	101 (14%)	232 (33%)	710
Providers of CAP-MR/DD services	522 (64%)	21 (3%)	276 (34%)	819

2007-2010 Accomplishments regarding High Quality Provider System

- ✓ Leadership training was provided to over 100 State and local consumer and family advisory committees (CFACs) on customer services, consumer rights, policies and rules and their responsibilities in representing consumers.
- ✓ Over 200 people attended three regional customer services and consumer rights trainings on policies and rules.
- ✓ Critical enhanced service definitions were revised to ensure appropriate clinical professional qualifications, strengthen eligibility criteria, and clarify key elements of the evidence based practices.
- ✓ Train the trainer events were held for all LME System of Care coordinators on the purpose and facilitation of child and family teams and on services such as Intensive In-Home and Multi-Systemic Therapy.

[6] The timeline to become nationally accredited was modified and the array of services requiring accreditation was expanded due to legislative mandates. S.L. 2008-107 established G. S. 122C-81 that set a new timeline of one year to attain national accreditation for community service providers who enrolled in the Medicaid program or who contracted for State-funded services on or after July 1, 2008. This provision also established benchmarks to track progress towards accreditation during that timeframe. The new CAP-MR/DD waivers stipulated that effective with implementation on November 1, 2008, existing CAP providers were required to become nationally accredited within one year and providers enrolled after November 1, 2008 had one year from their effective date of enrollment to become nationally accredited. The requirement for national accreditation of residential providers became effective with the signing of S.L. 2009-451 on August 7, 2009, where existing residential providers had one year from the signing of the legislation to become nationally accredited. Any provider enrolled after the enactment of S.L. 2009-451 is subject to the same endorsement and national accreditation requirements.

- ✓ Statewide provider performance standards were implemented in a phased approach:
  - Enrolling all providers into the NC CareLink system;
  - Implementing the Frequency and Extent of Monitoring (FEM) Tool and the Provider Monitoring Tool (PMT); and
  - Developing the Consumer Perception of Care Survey that will lead to provider performance reports.
- ✓ Statewide provider performance measures were refined and are reported quarterly in the Community Systems Performance Reports.
- ✓ Requirements established for providers' achievement of national accreditation.
- ✓ Technical staff assisted the NC Commission for MH/DD/SAS in publishing the Workforce Development Plan of 11 recommendations to the General Assembly.
- ✓ Continued development and implementation of the CAP-MR/DD tiered waivers including the Comprehensive Waiver that serves about 10,000 people, and the Supports Waiver that serves about 1,000 people with a Self Direction option.
- ✓ Published Analysis of Service Gaps in the MH/DD/SA Service System in April 2010 that compiles all LME needs assessment reports and provides a system-wide assessment of service needs.
- ✓ Obtained DHHS and CMS approval of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA), to improve accountability to individual consumers and the clinical competence and oversight of providers.
- ✓ Established three neuro-medical treatment centers with credentialing as skilled nursing facilities for individuals with chronic and complex medical conditions co-existing with neurological conditions consistent with a diagnosis of a developmental disability, or severe and persistent mental illness such as gero-psychiatric disorders or dementia such as Alzheimer's.
- ✓ The alcohol and drug abuse treatment centers (ADATCs) and State psychiatric hospitals clarified admission criteria and protocols, implemented a medical clearance policy and new medical transfer guidelines and established a seamless framework for referring individuals to one another.
- ✓ DSOHF supported and participated in formal training provided by various facilities to increase integration in the community and to improve continuity of care between community providers and state operated facilities.
- ✓ Based on a standardized survey of all guardians of individuals residing in the three developmental centers**,** five new six-bed Intermediate Care Facility for the Mentally Retarded (ICF-MR) group homes are planned to serve 30 individuals with complex behavioral and/or medical needs whose guardians are in favor of their moving to a community setting.

Continue development of comprehensive crisis services

Progress continues in establishing crisis services in North Carolina for individuals with mental health or substance abuse issues or with intellectual and/or developmental disabilities. The integration of crisis services into community systems of care is essential to meeting each individual's needs in a clinically appropriate and timely way.

A comprehensive crisis service system is critical to stabilize the public mental health, developmental disabilities and substance abuse services system across all disabilities statewide, ranging from community care to more intensive care in state operated facilities. To be most effective, community crisis services must be fully integrated with existing community medical and public safety emergency response systems. In addition, the State strives to ensure appropriate use of the State's psychiatric hospitals and alcohol and drug abuse treatment centers. In every case, the intent is to create positive outcomes for each individual served. These values have driven decisions and actions.

In early 2008, the Secretary of DHHS called for recommendations from a special advisory group of physicians, university professors, hospital administrators and LME representatives on the types of community crisis services needed. Although LMEs had begun implementation, services were not uniform across the state. Therefore, the Department requested additional funding from the General Assembly to support the further development of specific community crisis services statewide.

In July 2008, the General Assembly recognized the necessity of this endeavor and provided additional funding as shown in table 3 to ensure availability statewide of mobile crisis teams, various services and telepsychiatry equipment at walk-in clinics, local community hospital psychiatric beds, NC START teams and crisis respite beds.

Table 3. NC General Assembly Funding for Crisis Services

Year	Legislation	Funding	Purpose
July 2006	SB 1741	$5.2 M	For LMEs to develop long term plans and for operational start up of local crisis services
July 2007	HB 1473	$13.7 M	Continued implementation of the LMEs' crisis services plans
July 2008	HB 2436	$5.8 M	For 30 mobile crisis teams across the state
		$5.1 M	For walk-in crisis and immediate psychiatric aftercare
		$1.8 M	For start up of START crisis teams
		$1.1 M	For start up of crisis respite beds
		$8.1 M	For contracted community inpatient psychiatric beds
July 2009	SB 202	$12.0 M	For SFYs 2010 and 2011 for new contracts with community inpatient psychiatric beds

The Division worked with LMEs and providers to implement these services; progress made between 2007 and 2010 is identified for each below. See the Division's web site for current information: http://www.ncdhhs.gov/mhddsas/crisis_services/index.htm.

The action steps of the 2007-2010 strategic plan for crisis services focused on:

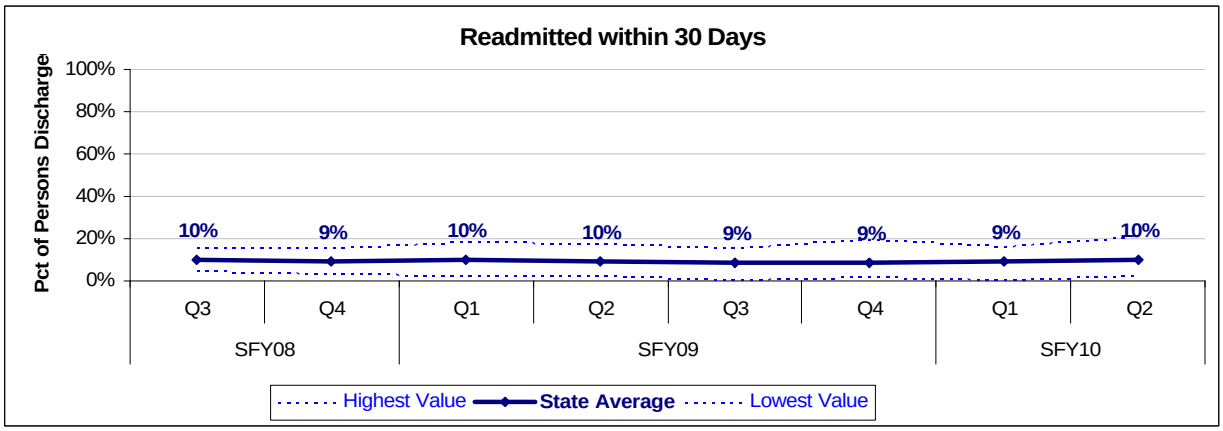
- Involvement of consumers and family members in crisis service planning.
- Comprehensive services and continuity of care.
- Training on crisis intervention and stabilization techniques.
- Cooperative relationships and protocols for care coordination among local crisis services and community hospitals, primary care physicians, clinics, networks and other community agencies.
- Appropriate use of state facilities.

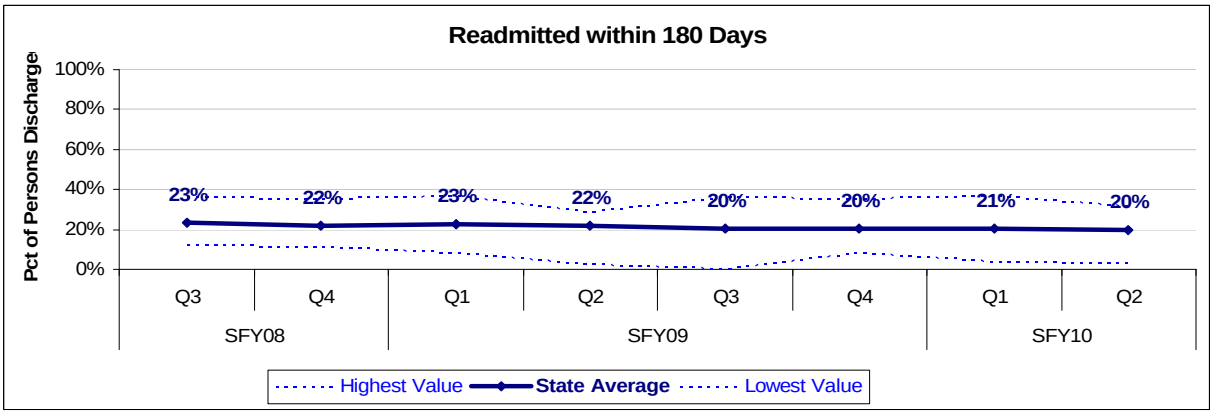
Measures of Objective

The overall effectiveness of progress in meeting this objective has been measured in terms of changes in consumer outcomes and system performance over time as indicated below and using SFY 2006-07 as the baseline. Although targets were not set in 2007, the measures show either stabilization or progress in the desired direction.

Reduced rate of re-hospitalizations within 30 days of inpatient discharge
Data Source: Community Systems Progress Report, State Psychiatric Hospital Readmissions

The data shows no change in the percentage of persons readmitted within 30 days; it has remained stable between 9-10 percent. However, the percentage of persons discharged who were readmitted within 180 days decreased steadily from 23% to 20%. An understanding of these data must take into consideration that the number of beds in the State psychiatric hospitals, and thus the number of admissions, have been reduced. Also, crisis services being established over this same time period increased the abilities of communities to respond in the long run.





Increased availability of local crisis services
Data Source: Data submitted by LMEs[7]

Mobile Crisis Teams: As of March 2010, North Carolina has 43 mobile crisis teams that cover the entire state hosted by 17 LMEs. A report on services provided by 32 of these mobile crisis teams between July 1 and December 31, 2009 shows 13,225 service requests were received primarily from hospital emergency departments, LMEs' screening/triage/referral units or crisis line, or by a consumer or family member. Other referrals were made by law enforcement, first responder/clinical home, other provider agencies, schools, the justice system, social services, and other public agencies. The majority of crises were resolved in the current setting or the individual was admitted to a community hospital psychiatric unit. Individuals were also referred to natural supports, a hospital emergency department, the state psychiatric hospital, jail, community detox program, a facility-based crisis center, crisis respite or a NC START team (see below), or an ADATC.

Walk-In Clinics: A status report dated March 2010 indicates a total of 89 walk-in crisis clinics in the 23 LMEs. In a February 2010, 17 LMEs reported active use of telepsychiatry communication equipment to allow a psychiatrist at a distant location to talk with and see consumers privately through closed-circuit television connections. This makes scarce psychiatric services available across the State, even in remote locations.

Contracts with Community Hospitals for Psychiatric Inpatient Beds: With goals to serve consumers in home communities and reduce short-term admissions to state hospitals, and in a collaborative partnership with the North Carolina Hospital Association, the Division had a positive response from community hospitals across the State to provide acute psychiatric care to indigent individuals. Begun in state fiscal year 2009, 11 hospitals signed contracts with the Division and a LME for 67 designated beds. As of June 2010, 20 contracts are signed that include 111 active inpatient beds.

[7] Additional information about these services can be found:
http://www.ncdhhs.gov/mhddsas/crisis_services/index.htm#startcrisisrespite

Readmission rates at local community hospitals are better than for state hospitals:

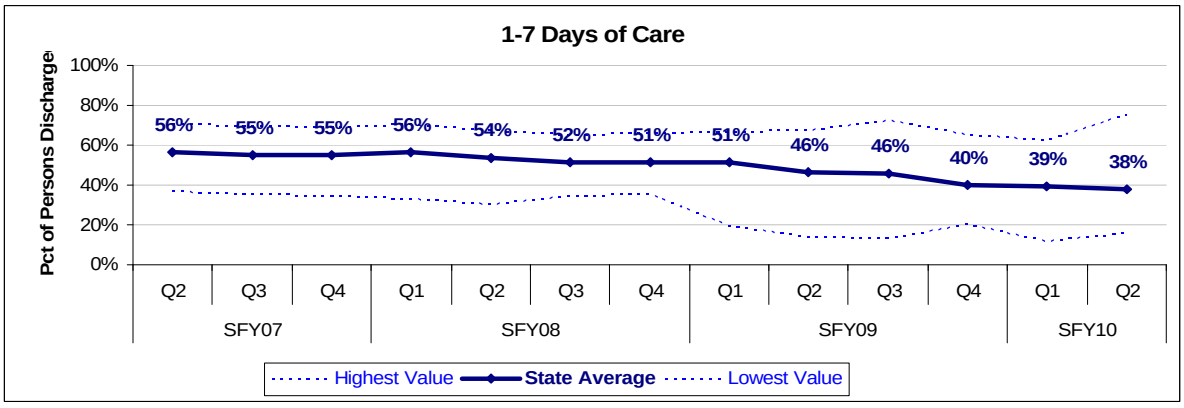
30-day readmission rate	Local = 6.2%	State = 10%
180-day readmission rate	Local = 11.2%	State = 20%

NC START and Crisis Respite: Each of the three regions of the State has two NC START teams and one 4-bed crisis respite facility hosted by one LME in each region. Reports from the teams indicate that the majority (66%) of all crisis calls to NC START teams resulted in the person's ability to remain in their current setting. An additional 16% were admitted to crisis respite beds; an additional 11% were admitted to community based inpatient mental health facilities with support of the NC START team, and 4% were hospitalized in state psychiatric hospitals. The total number of persons served statewide in SFY 09 was 332 and the total number of admissions to crisis respite for the state was 228.

Reduced proportion of State hospital admissions for short-term care
Data Source: Community Systems Progress Report, Effective use of state hospitals

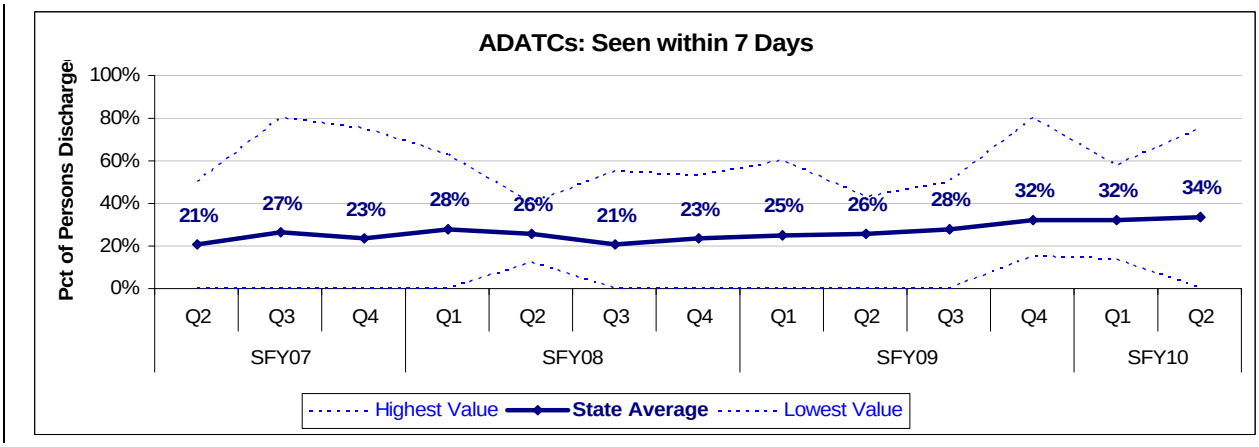
Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services and supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.

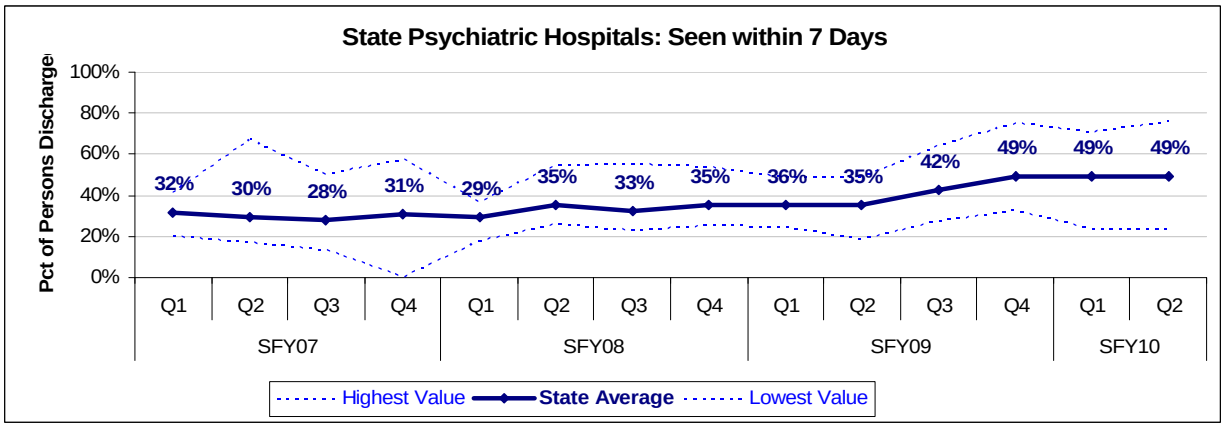
Between the beginning of state fiscal year 2007, and the middle of state fiscal year 2010, the percent of persons discharged after one to seven days of care has reduced 18 percentage points. This reduction may indicate a more appropriate use of State psychiatric hospitals for persons needing longer care, due to the increased availability of community crisis services.



Increased percentage of consumers receiving continuity of care between inpatient services and community care
Data Source: Community Systems Progress Report, Timely Follow-up after Inpatient Care

The following tables indicate that the percent of persons discharged from the ADATCs who are seen by a provider in the community within a week has increased from 21 percent to 34 percent in the last three years. Likewise, there has been an increase in the percent of persons discharged from the state hospitals who were seen by a provider in the community from 32 percent to 49 percent. It appears that efforts to provide continuity of care are successful. Some individuals who are discharged from these facilities have private insurance and are not seen by providers in the public system. Since the Division does not have reliable access to data from private insurers, those data are not included here.





Increased utilization of the Acute and Sub-acute (Acute Rehab) services in ADATCS.
Data Source: HEARTS

DSOHF restructured the state's three ADATCs to increase capacity to provide appropriate acute crisis care and treatment. During 2007-2010, each of the three state

alcohol and drug abuse treatment centers (ADATCs) expanded the number and use of beds for acute crisis and rehabilitation services.

Bed Expansion Status in Alcohol and Drug Abuse Treatment Centers

- Walter B. Jones ADATC in Greenville is fully operational with a new 24-bed acute crisis unit added in July 2008.
- J.F. Keith ADATC in Black Mountain expanded from 10 acute/crisis beds to become fully operational with a 30-bed acute unit.
- R.J. Blackley ADTAC in Butner expanded from 15 to 20 acute/crisis beds and will open all 30 acute/crisis beds as soon as the psychiatric staffing shortage is resolved.

As a result, the ADATCs served 1459 (that is over three times as many) individuals in acute crisis or acute rehabilitation in state fiscal year 2008 when compared to state fiscal year 2007. As shown in table 4, the ADATCs served 764 more individual in acute crisis substance abuse services in state fiscal year 2009 compared to state fiscal year 2008, a 40 percent increase and six times as many as served in 2007.[8]

Table 4. Acute Crisis Units Admissions SFY 07 - SFY 09

SFY	2007	2008	2009
ACU Admissions	430	1889	2653

2007-2010 Accomplishments regarding Comprehensive Crisis Services

The accomplishments made in community crisis services since 2007 resulted in increased services in communities enabling individuals to be closer to home while receiving emergency care, expanded acute care for individuals requiring medically monitored detoxification, and dedicated care coordination for individuals receiving needed intensive care in state psychiatric hospitals and ADATCs as they return home.

- ✓ The person centered planning format including the crisis prevention/intervention plan applicable to all disabilities was revised as part of the paperwork reduction project.
- ✓ The Consumer Handbook was created with the involvement of consumers and published as a guide and reference for all consumers and their families with regard to expecting quality service, choice of providers and their rights, and crisis prevention/intervention planning.

[8] Notes: WB Jones acute care unit opened July 2007; RJ Blackley data was not separated from JUH in FY 2007; JF Keith acute care unit opened January 2009 and its capacity fluctuated Jan-April 2009 impacting admissions.

- ✓ Training for over 100 members of State and local CFACs included quality management and "Building a Community Safety Net" as part of local crisis services planning with their LMEs.
- ✓ The North Carolina Risk Identification Tool was developed to discuss potential risks in the daily life of an individual with intellectual and/or developmental disabilities who is participating in the CAP-MR/DD waiver.
- ✓ A crisis services web page was created with links to LMEs' 24-hour access/crisis contact numbers, information about crisis services available across the State and a resource library for providers and LMEs.
- ✓ As of March 2010, North Carolina has 43 mobile crisis teams that cover the entire state that reported responding to 13,225 service requests between July 1 and December 31, 2009 with the majority of referrals made by hospital emergency departments, the LME STR / crisis line, or by a consumer or family member.
- ✓ A preliminary status report dated March 2010 indicates a total of 89 walk-in crisis clinics across the State with approximately 17 of the LMEs actively using telepsychiatry communication equipment.
- ✓ As of January 2009, each of the three regions of the State has two NC START teams and one 4-bed crisis respite facility hosted by one LME in each region. The majority (66%) of the 332 crisis calls to NC START in SFY 2009 resulted in the person's ability to remain in their current setting.
- ✓ As of June 30, 2010, 20 community hospitals have signed contracts with the Division and an LME to provide 111 psychiatric beds to serve consumers in their local community and to divert admissions from the state psychiatric hospitals.
- ✓ Each of the three state alcohol and drug abuse treatment centers (ADATCs) expanded the number and use of beds for acute crisis and rehabilitation services: Walter B. Jones ADATC in Greenville is fully operational with a new 24-bed acute crisis unit added in July 2008; J.F. Keith ADATC in Black Mountain expanded from 10 acute/crisis beds to become fully operational with a 30-bed acute unit; and R.J. Blackley ADTAC in Butner expanded from 15 to 20 acute/crisis beds and will open all 30 acute/crisis beds as soon as the psychiatric staffing shortage is resolved.
- ✓ Staff at all three ADATCs are trained in evidence based treatments - Motivational Interviewing (MI), Seeking Safety, and Solution Focused Brief Therapy (SFBT), for working with individuals receiving both acute crisis and acute rehabilitation services.
- ✓ Policies and procedures have been implemented to ensure the coordination of care between the services of a mobile crisis team or a walk-in crisis site to an appointment with a community provider.
- ✓ Each LME assigned a hospital liaison to ensure care coordination on site at the state psychiatric hospital that serves consumers from the LME's catchment area, including the preparation of a discharge plan with the person.

- ✓ The Division reports data from the Division of Public Health to LMEs on the numbers of individuals with a mental health or substance abuse diagnosis admitted to community hospitals emergency departments on a quarterly basis.
- ✓ Eighteen NC Crisis Intervention Training (CIT) programs have trained 2,135 law enforcement officers in 151 agencies in best practices of crisis intervention and stabilization techniques for working with individuals in crisis, resulting in decreased consumer and officer injury rates and unnecessary incarceration of individuals in crisis, and improved community relationships and the attitudes of law enforcement toward people with mental illness.
- ✓ A newly established NC CIT State Advisory Committee provides guidance on program activities, funding decisions and development of NC CIT conferences.
- ✓ A screening tool has been identified in collaboration with LME representatives, the Sheriff's Association, jail administrators, health providers in jails, and others for use in all NC jails and coordinating with LME designated staff for medication administration and facilitating an individual's return to treatment.
- ✓ The first level commitment evaluation pilot project has found statistically significant evidence to recommend that Master's level Licensed Clinical Social Workers (LCSW) and Licensed Clinical Addictions Specialists (LCAS) be allowed to perform first level commitment examinations statewide.
- ✓ The pilot to reduce State psychiatric hospitalization has successfully shown that all four LMEs in the project met their target reductions during the first pilot phase with 80 fewer admissions and 30 more individuals with readmissions within 30 days of discharge, yielding the lowest annualized rate in FY08-09 of utilization of the State hospitals in a decade.

Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system

The Division's intent of this objective was to (1) promote consistent access to services for consumers across the state according to their level of need, (2) increase the effectiveness and efficiency of all LMEs and providers by adopting standard processes and procedures, and (3) adopt consequences for lack of accountability at every level. Major concerns are utilization management of state-funded services, provider management, clinical protocols, care coordination, information systems and LME functions.

The action steps for this objective were:

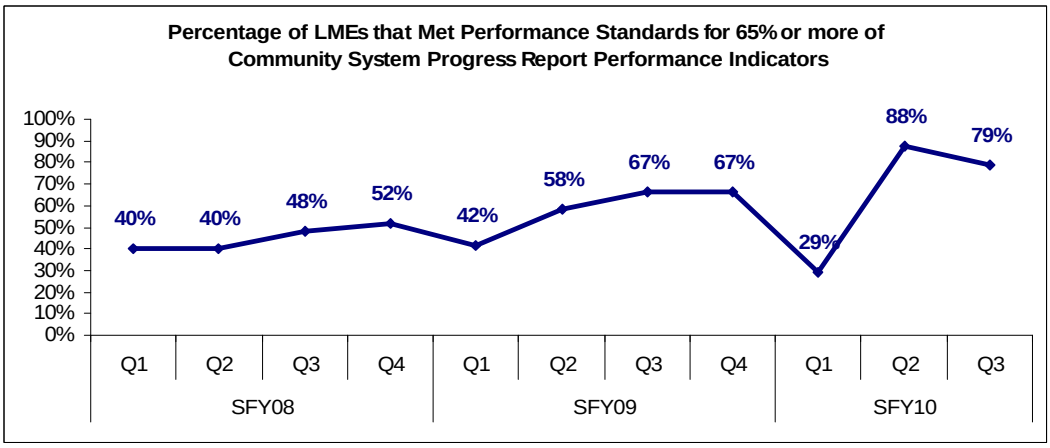
- Inform consumers and family members of statewide standard processes and of their legal rights.
- Implement uniform practices and clinical protocols for utilization review (UR) and utilization management (UM) for state funded services.
- Implement uniform practices and performance expectations for provider management, including provider endorsement, provider monitoring and claims payment.
- Implement uniform high quality clinical systems and protocols to assure care coordination and protocols for monitoring and continuity of care for consumers.
- Develop a consistent framework for care coordination of high risk and/or high cost consumers.
- Implement system wide outcome and performance measures to assure quality, effectiveness and accountability.
- Replace or upgrade existing information systems.

Measures of Objective

Percentage of LMEs meeting 65% of contract performance measures.
Data Source: Community Systems Performance Report

In SFY 2007 the performance of LMEs was measured, but performance standards had not been established. During SFY 2007 and the first half of SFY 2008, the number and type of performance indicators changed and performance standards were set. Contract performance measures address standard processes and procedures including timely access to care, services to persons in need, timely initiation and engagement in services, effective use of state psychiatric hospitals, readmissions, follow-up, and child services.

As shown in the chart below, LME performance on the indicators has improved overall since the first quarter of SFY 2008. Note that performance standards are adjusted each state fiscal year based on the prior year's performance, which results in a decrease in performance in the first quarter of each fiscal year. The number of LMEs decreased over time from 30 in SFY07 to 24 in SFY09.



Increased percentage of consumers receiving continuity of care between inpatient services and community care

Data Source: See the measures on continuity of care reported under the objective for Crisis Services

2007-2010 Accomplishments regarding Standardization

- ✓ The curriculum on client rights protection and other functions of local customer service and consumer affairs offices was developed and distributed to LMEs.
- ✓ The person centered planning format and manual applicable to all disabilities were revised as part of the paperwork reduction project including a one-page profile/description.
- ✓ Analysis of LMEs' UM/UR functions was conducted under contract by Mercer Inc.
- ✓ Four LMEs participated in a series of UR training events in anticipation of implementation of Medicaid UM targeted to begin in 2009. Two LMEs continue to participate in training and develop standardized procedures as they prepare to transfer the utilization review functions from ValueOptions.
- ✓ In collaboration with the Provider Action Advisory Council standard processes for service authorizations and claims processing were recommended for implementation.
- ✓ The Frequency and Extent of Monitoring tool (FEM) and the Provider Monitoring Tool (PMT) and manuals were developed and fully implemented in January 2009 to standardize the LMEs' monitoring of providers.
- ✓ A contract between LMEs and state operated facilities that identifies expectations regarding care coordination and continuity of care was developed and signed by LMEs and State facilities.
- ✓ Several policies and protocols have been developed and implemented by DSOHF that standardize continuity of care between the community and the state-operated

facilities, including the Regional Referral Form, the Bed Day Utilization Policy, the Homeless Discharge Policy and the Continuing Care Plan.

- ✓ System-wide performance measures were revised in the SFY2008 DHHS-LME performance contract and standards and targets were increased to reflect improvements in performance over the past year.
- ✓ CAP-MR/DD waiver quality management plan has been defined to include performance data for planning for entire system and not just waiver participants.
- ✓ The DHHS-LME performance contract measures are reported in the Community Systems Progress Reports on a quarterly basis, including a one page matrix for the Legislative Oversight Committee showing all LMEs' performance against standards and targets.
- ✓ Potential solutions have been identified for a community electronic health record that will allow LMEs and providers to manage the care given to their consumers, including coordination with state facilities and with the Community Care of North Carolina (CCNC) health information exchange (HIE) project. Funding of such a project is also challenging due to the economic situation.
- ✓ Recommendations for reducing the paperwork requirements of providers and LMEs have been identified including standardizing all forms statewide and the utilization of a community electronic health record and/or standard means to electronically communicate required data.
- ✓ At the direction of the Department and in coordination with DMA, waiver amendment requests were submitted to CMS to expand the 1915 (b)/(c) Medicaid waiver statewide with the intent to establish one or more additional LMEs operating both waivers through a prepaid inpatient health plan (PIHP).
- ✓ A request for applications from LMEs to participate in the State's 1915 (b)/(c) Medicaid waiver was published in February 2010 and the Department selected one LME to begin implementation in July 2010.

Improve Consumer Outcomes Related to Housing

In setting this objective, the Division recognized the importance of housing for the people we serve and advocated housing be addressed in every consumer's person centered plan. This is a complex area that involves persons who are homeless, keeping children in their home communities, housing that is tied to specific services, group homes, supported housing programs and multiple laws and funding options.

Other challenges affected the Division's ability to move forward with this objective, including staff reductions and the current economic situation. From the outset the Division acknowledges this is a long term endeavor.

Action steps for this objective included:

- Involve consumers in promoting the role stable housing plays in treatment, recovery, self-determination and/or full inclusion in the community.
- Develop strategies for implementing the Division's long-term integrated housing plan.
- Develop guidance, training and support for LMEs' housing specialists.

Measures of Objective

Increased percentage of consumers that report they have accessible, safe, stable housing in the community

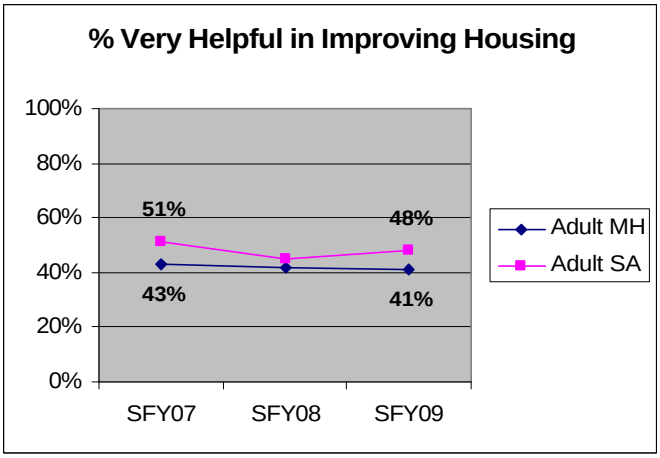
Data Source: National Core Indicators Project, Consumer Survey, Project Year FY 07-08; and NC Treatment Outcomes & Program Performance System (NC-TOPPS), Adult Mental Health (AMH) and Adult Substance Abuse (ASA) "matched reports"

In annual interviews with individuals with developmental disabilities in SFY 2007-08 regarding housing, 43 percent reported choosing where they live.[9]

In addition, DSOHF reported that during calendar year 2009, a total of 12 individuals successfully moved from the general population of the developmental centers to the community. All 12 individuals went directly from services at the developmental centers to services in the community.

As reported in NC-TOPPS, the percent of adult consumers of mental health and substance abuse services that reported services were very helpful in improving housing decreased over the last three years.

[9] See the Division's Semi-Annual System Performance Reports: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm Note that there is a two year lag in receiving National Core Indicators data.



Increased numbers of formerly homeless individuals with disabilities that are placed in housing

Data Sources NC-TOPPS for consumers of mental health and substance abuse services

Information available from NC-TOPPS is the actual numbers of consumers that reported being homeless three months before treatment began and then later if while in treatment they were homeless during in the past three months. The number of individuals who were homeless when entering services grew during the past three years. Consumers of substance abuse services who entered treatment and were successfully placed in housing during treatment increased from about one-third to almost one-half in SFY2009.

Table 5. Consumers Reporting Being Homeless Before and During Treatment

	MH Consumers			SA Consumers		
	Homeless before services	Moved into housing during services	**Percent Helped**	Homeless before services	Moved into housing during services	**Percent Helped**
SFY07	363	150	**41%**	402	138	**34%**
SFY08	558	204	**37%**	639	288	**45%**
SFY09	713	297	**42%**	720	342	**48%**

Increased number of affordable and accessible housing units available

Data Source: Reports from Oxford Houses

Oxford Houses are self-supported houses for recovering substance abusers. From 2007 through March 2010, 27 new Oxford Houses opened in North Carolina. Today there are a total of 136 Oxford Houses in the state providing more than 1,000 beds (743-men, 246-women and 23-beds for women and their children).

To open new Oxford Houses and provide peer support, $200,000 is available in annual recurring state appropriations and $50,000 from the federal Substance Abuse Prevention and Treatment Block Grant.

Increased outreach to homeless individuals

Data Source: Projects for Assistance in Transition from Homelessness (PATH) grant from the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA).

PATH funding is used to provide outreach and time-limited case management to individuals who are experiencing homelessness and have a serious mental illness or co-occurring disorders. Priority is given to individuals who are literally homeless - living in woods, streets or buildings not suitable for living. PATH programs must meet non-profit status. North Carolina PATH programs are located in Durham, Wilmington, Fayetteville, Chapel Hill, Charlotte, Statesville, Asheville, and Winston-Salem. PATH programs match the federal funding with state, county or other non-federal funding.

Table 6. Funding and Persons Served through PATH

	2007	2008	2009	Estimated 2010
PATH award	$932,000.00	$932,000.00	$914,000.00	$1,037,000.00
Local match	$531,901.00	$536,450.00	$545,552.00	$ 545,552.00
Persons contacted	5559	4853	5014	5250
Enrolled	775	952	999	985
% Homeless	80%	79%	80%	80%

In North Carolina, Continuum of Care community groups applied for the U.S. Department of Housing and Urban Development's (HUD) McKinney-Vento funds for homeless programs. McKinney-Vento funds are used for permanent supportive housing and/or services. The Continuum of Care process helps organize and deliver housing and services to meet the needs of people who are homeless as they move to stable housing and achieve self-sufficiency. The Continuum of Care planning process includes specific action steps to end homelessness and prevent a return to homelessness. Since 1998, the Continuum of Care planning shifted gradually to local communities. In response, DHHS and the Division provided technical assistance to local management entities to secure Shelter Plus Care housing opportunities for consumers of MH/DD/SA services.

Many LMEs have been critically involved in their community's application for federal Continuum of Care grants, sometimes taking the lead role in directly applying for funds. These local partnerships resulted in transitional housing and permanent housing as well as services for homeless people, including over 1,530 units of permanent housing. In 2009, the US Department of Housing and Urban Development awarded $15,084,732 in grants to twelve North Carolina Continuum of Care programs. The awards included funding to support the McKinney Shelter Plus Care, and the McKinney Supportive Housing Program. The Shelter Plus Care Program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program. Shelter Plus Care is designed to provide housing and

supportive services on a long-term basis for homeless persons with disabilities – primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases.

2007-2010 Accomplishments regarding Housing

This objective has involved four major, ongoing efforts: (1) encouraging every consumer's person centered plan addresses housing, (2) securing local affordable housing and supportive services, (3) working with LMEs' housing specialists, and (4) participating in initiatives and projects with the Department and other housing organizations.

- ✓ On an ongoing basis the Division's Housing Specialist provides training and technical assistance to the 27 housing specialists employed across all LMEs, including providing orientation for newly hired housing specialists, conducting quarterly statewide meetings for LME housing specialists, and providing consultation on the NC Landlord-Tenant and Fair Housing Laws.
- ✓ A consumer friendly housing brochure was developed and disseminated throughout the State to provide guidance for consumers, service providers, and the LME's customer service staff to communicate housing options for consumers.
- ✓ The Mental Health Trust Fund supported the Homeless Mental Health Housing Initiative Pilot Project during 2007-2009 focused on the homeless in Asheville, Durham and Guilford County. The initiative supported three full time housing support teams available 24 hours a day, 7 days a week to provide services and interventions for formerly homeless individuals with severe and persistent mental illness and that frequently use public support systems and cycle through psychiatric hospitals, treatment programs, jails and prisons. The teams help these individuals to maintain their housing and link them to other needed services such as medical, financial management and mental health and/or substance abuse services.
- ✓ The three housing support teams are now funded under the Homelessness Prevention and Rapid Re-Housing Program of the American Recovery and Reinvestment Act of 2009.
- ✓ In April 2008, the Division demonstrated continued support of the housing specialists at LMEs by providing funding for nine additional housing specialist positions. Currently, all 24 LMEs have one or more housing specialists.

✓ *Improve Consumer Outcomes related to Education and Employment*

The Division's vision calls for communities to work together to enable consumers to live successfully in their communities. Part of the challenge of developing a community based services system is transforming the community itself to be inclusive and to accept diversity. This includes opportunities for education, employment and asset development.

Other challenges affected the Division's ability to move forward with this objective, including staff reductions and the current economic situation. From the outset the Division acknowledges this is a long term endeavor.

Action steps included:

- Involving consumers and family members in promoting and emphasizing the role education and employment play in self-determination and/or recovery.
- Develop and communicate guidance for LME staff and providers about the importance of addressing education and employment in all person centered plans.
- Expand joint efforts with the Division of Vocational Rehabilitation to provide training for staff and employment opportunities for consumers.
- Develop strategies and disseminate information for consumers related to maintenance of benefits.
- Provide guidance to LMEs for assisting youth consumers to move into jobs, vocational development or post secondary education.
- Expand the availability of supported employment and job placement services and supports.

Measures of Objective

Proportion of consumers with intellectual or developmental disabilities (IDD) who report that they like their work and/or day program

Data Source: National Core Indicators Consumer Survey (NCI), available for SFY 2007, SFY 2008, and SFY 2009

The NCI survey indicates the following percentages of 339 respondents in North Carolina reported that they like their work and/or day program.

SFY 2006-2007	98%
SFY 2007-2008	94%.

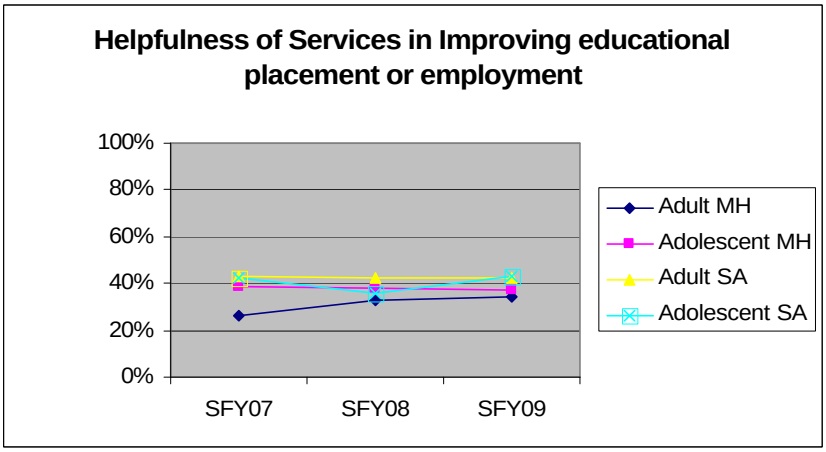
The results of the SFY 2009 NCI survey indicates that 28 percent of people report having a job in the community; 93 percent report liking their jobs and 32 percent report wanting to work somewhere else. Also of the respondents, 44 percent report they do not have a job but would like one.

In addition, 71 percent of people reported going to a day program or doing day activity; 85 percent report liking it; and 33 percent report wanting to go or do something else.

Information is not yet available for SFY 2010 from the national organization that publishes these data.

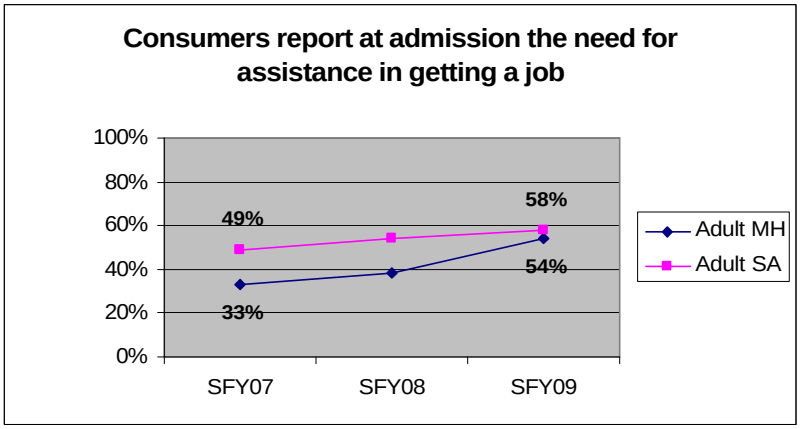
Increased percentage of consumers that report helpfulness of services in securing education or employment
Data Source: NC-TOPPS AMH and ASA matched reports

The percent of adult consumers of mental health services that reported helpfulness of services in improving educational placement or employment has increased over the three years from 26% to 34%. The percent of adolescents engaged in mental health services that report helpfulness has declined slightly from 39% to 37%. The reports of both adults and adolescents in substance abuse services remained about the same (adults 43% to 42%; adolescents 42% to 43%).

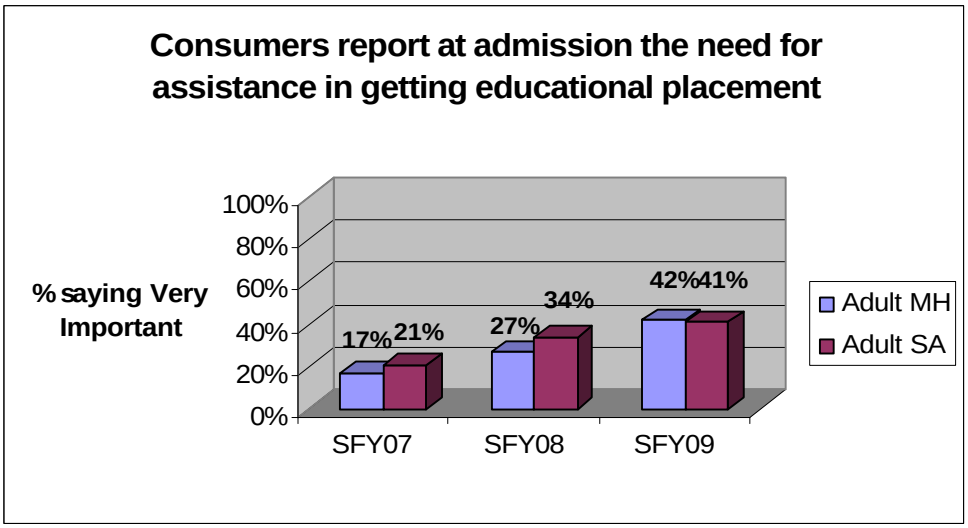


However, as shown in the next two measures, the percent of adult consumers at admission who report need for assistance in getting a job or educational placement increased over the same time period.

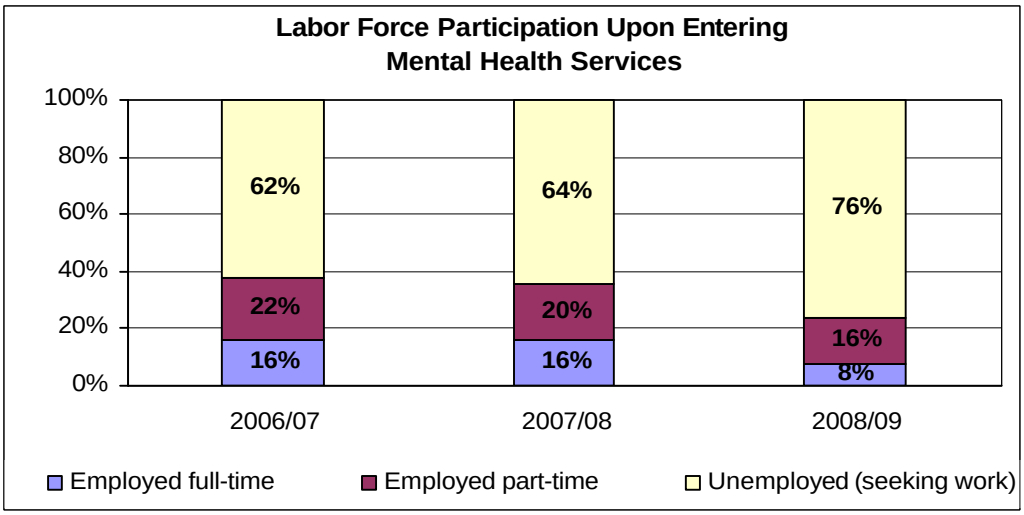
Percentage of consumers who report need for assistance at admission in getting a job
Data Source: NC-TOPPS AMH and ASA



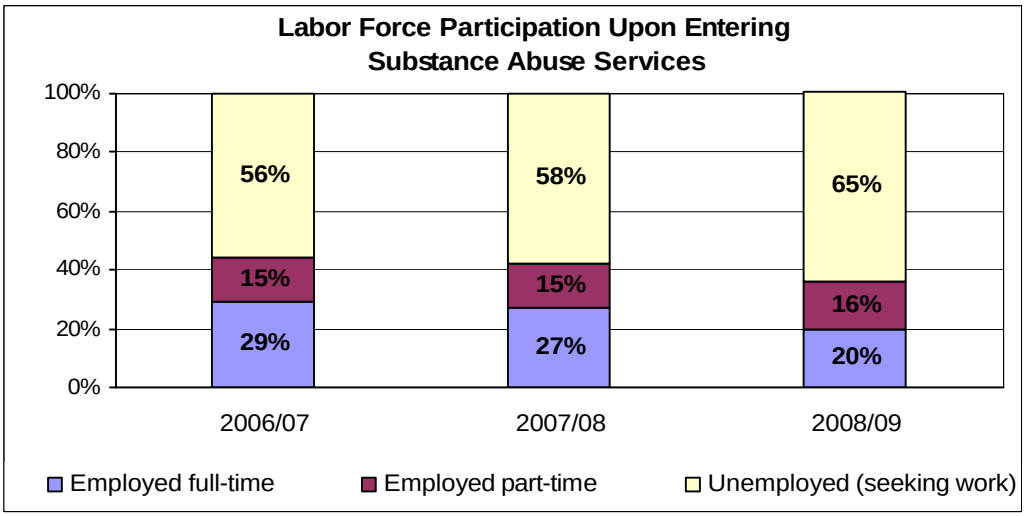
Percentage of consumers who report need for assistance at admission in getting educational placement
Data Source: NC-TOPPS AMH and ASA



As shown below, upon entering mental health services, the number of people looking for work over the last 3 years has increased. The percent of people in the labor force has increased from 44% to 49%; however, unemployment has also increased during this time. While receiving mental health treatment, employment dropped six to eight percent between SFY 2006/07 and SFY 2008/09.



Upon entering substance abuse services, the number of people looking for work over the last 3 years has increased. The percent of people in the labor force has increased from 67% to 73%. However, as shown in the graph below, unemployment has also increased during this time. While receiving substance abuse treatment, employment dropped twelve to twenty percent between SFY 2006/07 and SFY 2008/09.



2007-2010 Accomplishments regarding Education and Employment

- ✓ An interagency workgroup co-chaired by the Division and the Division of Vocational Rehabilitation (DVR) and including consumers, family members, LME representatives and other stakeholders participated in identifying multiple potential strategies regarding education and employment. The Division and DVR continue to meet on a regular basis and anticipate that exchange of policy and programmatic information will be ongoing.
- ✓ Although consumers and family members expressed few complaints about education and employment, the Division added these specific types of concerns to the existing complaints database for tracking purposes.
- ✓ The Division developed a brochure on supported employment for distribution to consumers through LMEs and providers.

Chapter 3. Where do we want to be?

Early in the process of mental health reform, the Division and its stakeholders invested time and energy in the development and adoption of a mission statement, vision, and guiding principles. Over the years, those statements have been refined as the system proceeded through periods of reform and transformation. Now, at a stage of standardization of the public system of mental health, developmental disabilities and substance abuse services, the basic values and principles still hold true.

Again refinement and enhancement is called for as the Division is included in a broader strategic planning process for the Department of Health and Human Services and all of State government. During SFY 2009-2010, Secretary Lanier Cansler set a new course for the Department with the introduction an initiative called DHHS Excels. This initiative is in coordination with Governor Beverly Perdue's Executive Order 3 to focus North Carolina's state government on efficiency, accountability and results.

The Department is leading a strategic planning process that will be reported to the Office of State Budget and Management in October 2010. Leadership and staff from all divisions and offices of the Department are participating in the initiative to (1) establish the department wide mission statement, vision, and values, and (2) develop goals and objectives. This initiative includes the Department's NC Open Window where the performance and cost of all services provided by the Department through its divisions and offices can be viewed by the public.[10]

This strategic planning document is prepared in response to legislation (Session Law 2006-142, HB 2077) that calls for DMHDDSAS to publish a three year strategic plan by July 1, 2010. In an effort to coordinate the requirements of the legislatively mandated strategic plan and the DHHS Excels initiative, this document is viewed as an early step in the department wide and more detailed strategic planning process for the State.

The DHHS Excels process of specifying detailed goals, objectives, performance measures and budgetary analysis requires an extensive period of time that goes beyond the due date for the legislative strategic plan. Therefore, chapter 4 of this document gives a general description of the strategies to which the Division is committed for upcoming three to five years. Information on detailed action steps and performance measures will be included in the DHHS strategic plan.

Mission Vision and Values

As shown in table 7, the Division's mission, vision and values are in agreement with the direction taken by the Department. The DHHS mission and vision are inclusive all North Carolinians, while the Division's focus is specifically on those individuals with mental health or substance abuse issues or with intellectual and/or developmental disabilities. The Division

[10]See: http://dhhsopenwindow.nc.gov/index.aspx?pid=visionmission

remains committed to its original mission, vision and guiding principles, and is participating in the Department's broader view as well.

Goals of DHHS Excels

Through a participatory process, five departmental goals address and support the Department's mission and vision and incorporate the newly established values. A key result of DHHS Excels is a statement of five goals that:

- Reflect and support a person-centered, integrated approach
- Reflect and support the continuum of care and interrelatedness of service delivery as well as the "checks and balances" of what DHHS does.

The DHHS goals are:

- ***Manage resources that provide an elevated level of effective and efficient delivery of services and programs to North Carolinians.***

- ***Expand understanding and use of information to enhance the health and safety of North Carolinians.***

- ***Offer outreach and services to individuals and families identified as being at risk of compromised health and safety.***

- ***Provide services to individuals and families experiencing health and safety needs.***

- ***Provide services and protection to individuals and families experiencing serious health and safety needs that are not, at least temporarily, able to assist themselves.***

A process is underway with the Department's leadership to define objectives for each goal that are applicable to children or adults or families. The services overseen by all divisions of the Department are being aligned with the five goals and objectives for each goal. Progress can be viewed in NC DHHS Open Window online.[11] Outcomes and budgetary information is available by service.

[11] See: http://dhhsopenwindow.nc.gov/

Table 7. Alignment of DHHS and Division Mission, Vision and Values

DHHS Mission Statement	DMHDDSAS Mission Statement
The North Carolina Department of Health and Human Services, in collaboration with its partners, protects the health and safety of all North Carolinians and provides essential human services.	*North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.*
DHHS Vision Statement	**DMHDDSAS Vision Statement**
All North Carolinians will enjoy optimal health and well-being.	❖ *Public and social policy for people with disabilities will be respectful, fair and recognize the need to assist all that need help.* ❖ *Services for persons with mental illness, intellectual and/or developmental disabilities and substance abuse problems will be cost effective, will optimize available resources – including natural and community supports – and will be adequately funded by private and public payers.* ❖ *System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.* ❖ *All organizations and individuals that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.*

DHHS Values

When all DHHS employees adhere to the following values, all North Carolinians will view DHHS as the best managed agency in state government:

- **Customer-focused.** North Carolinians are the center of our service design and delivery, and allocation of human and fiscal resources.
- **Anticipatory.** DHHS uses feedback from our customers and partners on all levels -- national, state and local -- to guide our thinking, planning, policies and practices.
- **Collaborative.** DHHS values internal and external partnerships.
- **Transparent.** DHHS shares information, planning and decision-making processes and communicates openly with its customers and partners.
- **Results-oriented.** DHHS emphasizes accountability and measures its work by the highest standards.

DMHDDSAS Guiding Principles

- **Participant driven.**
- **Community based.**
- **Prevention focused.**
- **Recovery and/or self-determination outcome oriented.**
- **Reflect best treatment/support practices.**
- **Cost effective.**

Chapter 4. The Next Generation

The Division continues commitment to the five objectives defined in Strategic Plan 2007-2010. The objectives are:

- ***Establish and support a stable and high quality provider system with adequate number and choice of providers of desired services.***
- ***Continue development of comprehensive crisis services.***
- ***Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system.***
- ***Improve consumer outcomes related to housing.***
- ***Improve consumer outcomes related to education and employment.***

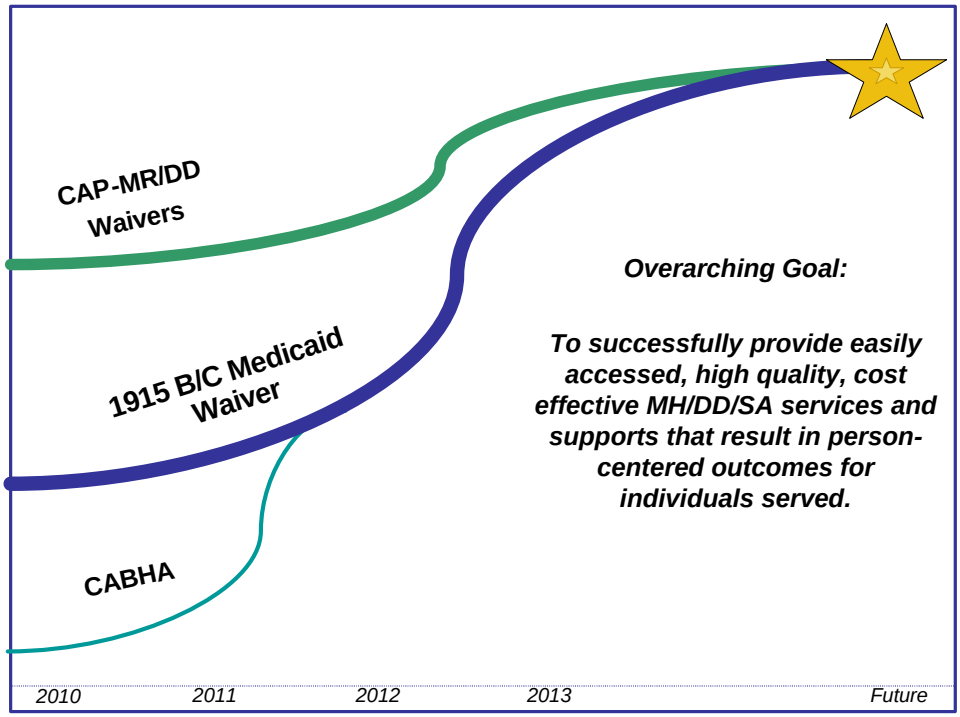
During the past three years, several specific strategies evolved as having the greatest potential for effective standardization of the public MH/DD/SA services system and for meeting these objectives. These strategies define the work of the Division during July 1, 2010 to June 30, 2013.

While the collaborative planning process with DHHS is underway, at this time the Division's strategies have not been specifically linked to the Department's five goals. The strategies are not unrelated to the five goals; yet, there is one main difference. The Department's goals are focused on the ongoing operation of the system of services. The Division's strategies are focused on further development of the system to enable it to meet desired standards of the operating system.

Three of the priority strategies are:

- Continued development and administration of the Community Alternatives Program-Mental Retardation/Developmental Disabilities Waiver (CAP-MR/DD).
- Implementation of the Critical Access Behavioral Health Agency model (CABHA) for mental health and substance abuse services.
- Expansion of LMEs' participation in the State's 1915 (b)/(c) Medicaid waiver.

Both the CABHA and the CAP-MR/DD waiver are based in the objective of establishing high quality providers. The 1915 (b)/(c) Medicaid waiver is an outgrowth of the objective to achieve integrated and standardized processes and procedures.



As shown in the diagram above, these priorities fit together to achieve an overarching goal. Continuing the development and administration of the CAP-MR/DD tiered waiver offers a more individualized service array to more people with developmental disabilities while managing costs. The CABHA strengthens the clinical and administrative oversight and quality of services for people with substance abuse and mental health issues. Expansion of the State's 1915 (b)/(c) Medicaid waiver provides greater accountability and flexibility for LMEs' management of all services locally and standardization statewide. Given the anticipated positive effects for the system over time, the Division is actively engaged with a focus of considerable resources in these three strategies.

In addition the Division is committed to the following strategies:

- Continuing integration of mental health and substance abuse services with primary heath care.
- Ensuring successful performance of local crisis services.
- Improving guidelines for involuntary outpatient and inpatient commitment processes.
- Continued collaboration with State and local partners regarding housing, employment and education.
- Increasing effective management of the overall system.
- Increasing consumer and family ownership of health care and supports.
- Increasing the quality of an array of mental health services, of substance abuse services, and of supports and services for individuals with developmental disabilities.
- Improved information management.

As these strategies are implemented over the next three years, the Division intends for the system to become more responsive, accountable and results oriented. This vision can only be realized through partnership with LMEs and other State agencies and the collaborative efforts of all stakeholders.

In addition to the strategies to further development of the system, the Division remains committed to the many programs and services it administers including those supported by the Substance Abuse Prevention and Treatment Block Grant, the Mental Health Block Grant, and other funding sources.

Support for these strategies was found in the Division's report entitled *Analysis of Service Gaps in the MH/DD/SA Service System* published in April 2010. This report is a compilation of all LME needs assessment reports and provides a system-wide assessment of service needs. The service gaps and needs that these stakeholders identified fall into six themes: (1) Long Term Supports for Independence and Recovery, (2) Quality and Accountability, (3) Workforce Development, (4) Expansion of Services, (5) Services for Vulnerable Populations, and (6) Leadership and System Management.

The Department has taken into consideration these identified needs, recent efforts in these areas, 2009 legislative requirements, the current economic situation, and the State's long-term goals for the MH/DD/SA service system in developing its immediate priorities. The priorities of the Department for the MH/DD/SA service system are to improve the quality and stability of the service system, maximize use of existing resources, and protect critical core services, including crisis services.[12]

CAP-MR/DD

The Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD) is a special Medicaid program started in 1983 to serve individuals who would otherwise require care in an intermediate care facility for people with the mental retardation/developmental disabilities (ICF/MR). It allows individuals the opportunity to be served in the community instead of residing in an institutional or group home setting.

CAP-MR/DD operates under a Medicaid home and community-based services waiver granted by the Health Care Financing Administration (HCFA). HCFA approves the services, the number of individuals that may participate, and other aspects of the program. The participants must be at risk of institutionalization. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care.

The Division administers the CAP-MR/DD program and LMEs are responsible for operation at the local level. DMA, as the State Medicaid Agency, provides oversight in

[12] See this report: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

relation to Medicaid and waiver issues. The written waiver approved by CMS is the authority and basis for the first clinical policy for such waivers. This policy helps with appeals and aligns with mental health and substance abuse services.

In 2007 the State began administration and continued development and implementation of the CAP-MR/DD tiered waivers including the Comprehensive Waiver that serves about 10,000 people, and the Supports Waiver that serves about 1,000 people with a Self Direction option. These are the first of three tiers each with a financial cap, thus allowing more people to be served.

The Division continues its commitment to this strategy to:

- Offer a more individualized service array.
- Serve more people.
- Manage costs.
- Provide greater flexibility in service delivery.

Steps to be taken in SFY 2011 will involve:

- Research and develop a short term waiting list tool and protocol.
- Develop optional long term strategies and costs with LMEs regarding the waiting list.
- Implement the quality management evidence packet when given CMS approval.
- Implement the prioritization tool.
- Fully implement the Self Direction option in the Supports waiver.
- Provide focused training for individuals on the Self Direction option including employer of record, agency of choice, community resource consultant, and the financial management services agency (FMS).
- Coordination decisions and lessons learned with the 1915 (c) waiver.
- Develop the third tier.
- Revise and submit to CMS waiver applications for all three tiers for implementation in the fall of 2011.

Additional information is available on the Division's web page:
http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm

CABHA

After multiple audits and concentrated analysis of the use of mental health and substance abuse services statewide since 2006, DMHDDSAS and DMA recognized the need for a new strategy to improve accountability to individual consumers and to improve the clinical competence and oversight of providers. Therefore, during state fiscal year 2009-

2010, DHHS approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA).[13]

The Division anticipates the strategy to implement CABHAs will move the public system to a more coherent service delivery model that reduces clinical fragmentation at the local level. The approach will prepare the provider community for the changes that will be required in a Medicaid waiver environment. (See 1915 (b)/(c) Medicaid Waiver below.)

A CABHA is designed to:

- Ensure critical services are delivered by a clinically competent organization with appropriate medical oversight.
- Ensure consumer care is based upon a comprehensive clinical assessment and person centered plan.
- Deliver an array of mental health and/or substance abuse services for a selected population to be served.

The strategy is to elevate the clinical, oversight and administrative requirements of providers of core services, to regulate who can provide other specific services, and to require a certification process. A CABHA will provide case management services (both Medicaid/ State funded) and peer support services for mental health and substance abuse consumers (after case management services are approved by CMS for implementation).[14] Another expectation is for the CABHA to maintain close collaboration with primary care physicians, public health departments, federally qualified health clinics, and Community Care of NC, in order to ensure consumers being served are treated in a holistic manner that addresses both their behavioral health and physical health care needs.

The array of services chosen by a CABHA varies depending upon the age and needs of the consumers being served by the agency. For example, a provider that serves only children with mental health issues would offer core required services of clinical assessment, outpatient therapy, case management, and medication management, plus two additional services such as intensive in-home and day treatment.[15]

Future steps to be taken include:

- Continued review of applications submitted by providers to become a CABHA including desk reviews, on site reviews and peer interviews.

[13] CABHA requirements do not apply to services for individuals with intellectual/developmental disabilities. Targeted Case Management for consumers with developmental disabilities will continue to be delivered outside the CABHA requirements.

[14] Effective January 1, 2010, Case Management services not included within a "clinical home" service definition will only be delivered through CABHAs. Once the service definition for Peer Support is approved by the CMS, the only agencies allowed to provide that service will be CABHAs.

[15] While CABHAs may deliver a broad array of services, please note that a number of enhanced services may still be delivered by providers who are not certified as CABHAs.

- Provision of training and oversight of implementation and operations of approved providers as CABHAs.

More detailed information about the CABHA and on-going updates made to the CABHA policy can be found on the DMH/DD/SAS web page: http://www.ncdhhs.gov/mhddsas/cabha/index.htm.

1915 (b)/(c) Medicaid Waiver

The expansion of North Carolina's 1915 (b)/(c) Medicaid waiver is a major commitment strengthened in 2009 as a collaborative effort within the Department involving the Division and the Division of Medical Assistance (DMA). The aim is to restructure the delivery system for Medicaid funded mental health, developmental disabilities and substance abuse services. The decision was based on the progress and successes of the DHHS pilot project of a Medicaid waiver begun in April 2005.[16]

The Department has selected one additional LME to participate in the 1915 (b)/(c) Medicaid waiver along with PBH beginning in state fiscal year 2011. Assuming the new LME replicates the success of the project in the PBH catchment area and together improve on progress, DHHS intends to phase in additional LMEs to operate the waiver with the long range goal of implementation statewide based upon continued proven success. Therefore, LMEs will have future opportunities to apply to participate in the waiver as North Carolina and the federal Centers for Medicare and Medicaid Services (CMS) plan the State's waiver expansion.

The performance of the system will be measured over the long term as additional LMEs participate in the 1915 (b)/(c) Medicaid waiver to determine how well the strategy meets three primary goals for North Carolina. These goals are:

- Improved access to services.
- Improved quality of all services.
- Improved cost benefit.

Each LME approved to participate in the waiver will operate Medicaid funded services in their geographic area through a capitated pre-paid inpatient health plan (PIHP). The Division will provide clinical and management oversight of participating LMEs, while DMA will pay each participating LME per member/per month (PMPM) capitated payments based on an actuarial analysis of population and service costs. LMEs operating a PIHP will be responsible for complying with all terms and conditions of a contract with the Division of Medical Assistance, including but not limited to: recruiting and credentialing providers, developing and overseeing a comprehensive provider network that assures timely access to services for all enrollees, authorizing payments for services,

[16] See chapter 2 for additional information under the objective entitled Integrated and Standardized Processes and Procedures.

processing and paying claims, and conducting care management, utilization management and quality management functions.

LMEs that participate in the waiver continue current obligations and commitment to the management of state funded mental health, substance abuse and developmental disabilities services as specified in a newly defined performance contract with the Division. See the 1915(b)/(c) waivers and waiver amendments, the request for applications, minimum requirements and draft contracts posted on the DMA and the DMH/DD/SAS websites.[17]

Steps to be taken in SFY 2011 by the Division in collaboration with DMA and the participating LMEs to implement expansion will require:

- Securing CMS approval of expansion to selected LME.
- Engaging consumers and families in every step of the process.
- Developing a start up and implementation plan of action.
- Signing contracts with selected LME at the beginning of full implementation.
- Facilitating access to real time data to increase management of waivers at LME and State levels.
- Developing standardized policies and procedures for implementation including authorization for all services, utilization management, rates, risk reserve, (b)(3) services, performance measures, provider endorsement & monitoring, and information technology improvements.
- Establishing a new Interagency Monitoring Team to monitor progress of implementation and performance outcomes of newly implemented waiver LMEs and making adjustments in operations as needed.
- Comparing outcomes of waiver LMEs with standard LMEs to determine success.
- Working with standard LMEs as they prepare for waiver implementation in the future.
- Seeking additional applications from LMEs to participate in the waiver in upcoming fiscal years.

Other Ongoing Strategies

- **Continuing integration of mental health, developmental disabilities and substance abuse services with primary heath care.**
  Integration of services with primary health care can be strengthened through care management protocols, coordination with high cost/high risk consumers, co-location, screening, electronic health records, evidence based models of care and additional internship and training opportunities. Collaboration will continue with Community Care of North Carolina's program to organize community health networks and to

[17] See the Division's web page for additional information: http://www.ncdhhs.gov/mhddsas/waiver/index.htm

achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

- **Ensuring successful performance of local crisis services**.
  Local crisis services can be further integrated with community emergency response through clarification of protocols, expanded use of telemedicine, improving first responder and crisis services capacity, and increased medical/clinical oversight of services. Division staff is working with staff of mobile crisis teams, hospital emergency departments, walk-in clinics and law enforcement to clarify roles, expertise, procedures, and continuity of care in the community. The goal is to achieve uniform crisis services throughout the State.

- **Improving guidelines for involuntary outpatient and inpatient commitment processes**.
  Support is needed for permanent approval to train and employ additional categories of licensed clinicians to perform first commitment evaluations and expand statewide.

- **Increasing effective management of the overall system.**
  System management can be strengthened through continued customer focus, effective use of system performance and consumer outcome data, transparency, collaboration, responsiveness, utilization management and review, and consistent local system management with clear roles, accountability, and economies of scale.

- **Increasing consumer and family ownership of health care and supports**.
  The Division continues to provide and encourage opportunities for self direction, peer support services, person-centered planning, and self advocacy.

- **Increasing the quality of an array of mental health services for children and adults**.
  Activities are focused on increased community psychiatric inpatient capacity, community crisis services, care coordination after discharge from psychiatric inpatient care, peer support services, community child mental health services, therapeutic family services, housing, education, employment and other recovery oriented services and supports.

- **Increasing the quality of an array of substance abuse services for children and adults.**
  Activities are focused on increased use of evidence based practices, flexible purchasing of substance abuse services, technical financial assistance to providers, and expansion of cross area service providers (CASPs) as well as housing, education, employment and other recovery oriented services and supports.

- **Increasing the quality of an array of services and supports for children and adults with intellectual and/or developmental disabilities.**

Activities are focused on development of a new traumatic brain injury (TBI) waiver, improved use of NC START with mobile crisis and crisis respite, use of the Supports Intensity Scale (SIS), waiting list methodology, improved use of State funds for intellectual and/or developmental disabilities, as well as housing, education, employment and other supports.

- **Improving information management.**
  The Division supports system upgrades, data sharing among components of system, use of electronic health record, paperwork reduction, improved payment system, and financial budgeting, reporting and auditing.

Summary

Taken together, these strategies will help to more fully manifest the broader vision begun nine years ago when reform legislation was first passed. The strategies support the building of a system with a firm foundation to provide good quality care and to express core mission and values. With an emphasis on less reliance on state institutions and more on the availability of local services and supports in our cities and towns, North Carolina's communities will be welcoming places for residents who have mental health or substance abuse issues or intellectual and/or developmental disabilities.

With continued focus on the strategies described above, the Division looks forward to a stable and standardized system of provider agencies and LMEs that have high standing in their communities due to their professionally recognized capability to provide the best care for the people we serve and to effectively and efficiently manage available resources. Trust and confidence will be restored and enhanced in providers of services, local management and in State government.